

**§ 409.49 Excluded services.**

(a) *Drugs and biologicals.* Drugs and biologicals are excluded from payment under the Medicare home health benefit.

(1) A drug is any chemical compound that may be used on or administered to humans or animals as an aid in the diagnosis, treatment or prevention of disease or other condition or for the relief of pain or suffering or to control or improve any physiological pathologic condition.

(2) A biological is any medicinal preparation made from living organisms and their products including, but not limited to, serums, vaccines, antigens, and antitoxins.

(b) *Transportation.* The transportation of beneficiaries, whether to receive covered care or for other purposes, is excluded from home health coverage. Costs of transportation of equipment, materials, supplies, or staff may be allowable as administrative costs, but no separate payment is made for them.

(c) *Services that would not be covered as inpatient services.* Services that would not be covered if furnished as inpatient hospital services are excluded from home health coverage.

(d) *Housekeeping services.* Services whose sole purpose is to enable the beneficiary to continue residing in his or her home (for example, cooking, shopping, Meals on Wheels, cleaning, laundry) are excluded from home health coverage.

(e) *Services covered under the End Stage Renal Disease (ESRD) program.* Services that are covered under the ESRD program and are contained in the composite rate reimbursement methodology, including any service furnished to a Medicare ESRD beneficiary that is directly related to that individual's dialysis, are excluded from coverage under the Medicare home health benefit.

(f) *Prosthetic devices.* Items that meet the requirements of § 410.36(a)(2) of this chapter for prosthetic devices covered under Part B are excluded from home health coverage. Catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care are not considered prosthetic devices if furnished under a home health plan of care and

are not subject to this exclusion from coverage.

(g) *Medical social services provided to family members.* Except as provided in § 409.45(c)(2), medical social services provided solely to members of the beneficiary's family and that are not incidental to covered medical social services being provided to the beneficiary are not covered.

[59 FR 65497, Dec. 20, 1994; 60 FR 39123, Aug. 1, 1995]

**§ 409.50 Coinsurance for durable medical equipment (DME) furnished as a home health service.**

The coinsurance liability of the beneficiary or other person for DME furnished as a home health service is 20 percent of the customary (insofar as reasonable) charge for the services.

[51 FR 41339, Nov. 14, 1986. Redesignated at 59 FR 65496, Dec. 20, 1994]

**Subpart F—Scope of Hospital Insurance Benefits****§ 409.60 Benefit periods.**

(a) *When benefit periods begin.* The initial benefit period begins on the day the beneficiary receives inpatient hospital, inpatient CAH, or SNF services for the first time after becoming entitled to hospital insurance. Thereafter, a new benefit period begins whenever the beneficiary receives inpatient hospital, inpatient CAH, or SNF services after he or she has ended a benefit period as described in paragraph (b) of this section.

(b) *When benefit periods end—*(1) A benefit period ends when a beneficiary has, for at least 60 consecutive days not been an inpatient in any of the following:

(i) A hospital that meets the requirements of section 1861(e)(1) of the Act.

(ii) A CAH that meets the requirements of section 1820 of the Act.

(iii) A SNF that meets the requirements of sections 1819(a)(1) or 1861(y) of the Act.

(2) For purposes of ending a benefit period, a beneficiary was an inpatient of a SNF if his or her care in the SNF met the skilled level of care requirements specified in § 409.31(b) (1) and (3).